

April 7, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M2-03-0735-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

\_\_\_, a 42-year-old gentleman, sustained injury to his lower back on \_\_\_. The patient did not do well with conservative treatment and he therefore required a laminectomy bilaterally at the L5/S1 interspace by \_\_\_, a spine surgeon. Initially, after his surgery he did extremely well and was relieved of his leg pain. However, the record indicates that he developed much more severe leg pain on April 19, 2001. This low back and leg pain developed, though there was no new injury. The records indicates that the patient was fired from his job at about that same time, but that the firing was unrelated to the development of the more pain going down the left leg. The pain became more severe and was persistent. He saw \_\_\_ again. \_\_\_ did an MRI that demonstrated evidence of thecal sac indentation at the lower three levels and evidence of degenerative lumbar disc disease.

\_\_\_ also developed a decreased left ankle jerk along with the increased amount of left leg pain. Due to the neurological findings and the increasing amounts of pain, a CT myelogram has been requested by the spine surgeon to evaluate whether or not this patient has any stenosis that would require further surgery.

#### REQUESTED SERVICE

A CT myelogram is requested for this patient.

## DECISION

The reviewer disagrees with the prior adverse determination.

## BASIS FOR THE DECISION

The reviewer finds that the requested myelogram and CT scan should be done as part of the present work-up to address the increasing pain that \_\_\_ is experiencing. This patient is having much more leg pain and many more neurologic problems, as are evidenced by his diminished left ankle jerk. It is apparent that he is not doing well with conservative treatment. The surgeon is requesting the myelogram and CT scan to further evaluate his back for potential repeat surgery. The reviewer finds that the requested service is both reasonable and necessary in this case.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

## YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 7th day of April 2003.**